

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-048051

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 298

FILED DEC 21 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>St Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWNSHIP <u>St Charles</u>		Length of stay in 1b <u>D.O.A</u>	c. CITY OR TOWN <u>St Charles</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Joseph Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt #1</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>David</u> Last <u>Arnold</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>10</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/21/1921</u>
9. AGE (last birthday) <u>41</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. of Schools</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	11. BIRTHPLACE (City and state or country) <u>Blairsville Ill</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Wayman E. Arnold</u>	
13b. MOTHER'S MAIDEN NAME <u>Bertie Smith</u>		14. NAME OF HUSBAND OR WIFE <u>Magdalene Arnold</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W. 2</u>		16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT <u>Magdalene Arnold Rt 1 St Charles</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>St Charles Mo</u> COUNTY <u> </u> STATE <u> </u>
21. I attended the deceased from <u>8:30-62</u> to <u>Dec 10 1962</u> and last saw him alive on <u>Dec 10, 1962</u> Death occurred at <u>8:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>WA Poggenmeyer MD</u> (Degree or title)	
22b. ADDRESS <u>St Charles Mo</u>		22c. DATE SIGNED <u>Dec 12, 1962</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/13/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cem. I.R.</u>	23d. LOCATION (City, town, or county) <u>St Louis Co Mo</u> (State)
24. FUNERAL DIRECTOR <u>Arthur C Baue Funeral Home</u> <u>St Charles Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 13, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>

DEC 27 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Connie T. Pickering

Licensed Embalmer No. 5789

P. O. Address St Charles, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.